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ABSTRACT

Despite the recent, unprecedented growth of school-based health centers and the related increased support from state government, the future of school-based health centers is uncertain. Since they can no longer rely on federal support, private insurance, or other commercial sources, each state must develop its own approach to supporting the centers. A critical precondition for creating a financial strategy is for each state to address the following questions: (1) What is a school-based health center? (2) Whom should the school-based health center serve if the center is to secure public funding? (3) What specific services must be provided? (4) How will these services be paid for and who will receive payment? This paper discusses approaches to answering these questions. Topics include difficulties related to financing school-based health centers through third-party payments, recent events which have had a major impact, the essential step of defining a school-based health center, and alternative reimbursement models as funding strategies. Six figures and three tables present data and statistical analysis. An appendix presents 1994 state guidelines for school-based health centers. Contains 37 references. (RB)

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MAKING THE GRADE

STATE AND LOCAL PARTNERSHIPS TO ESTABLISH
SCHOOL-BASED HEALTH CENTERS

ED 401 507

Issues in Financing School-Based Health Centers:

A Guide for State Officials

September 1995

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Issues in Financing School-Based Health Centers: A Guide for State Officials

Despite the recent, unprecedented growth of school-based health centers and the related increased support from state governments, the future of school-based health centers is uncertain. Proposed cut-backs in government spending may limit previously available public health dollars and state governments that intend to include school-based health centers in their health care networks for school-age children must now determine how to ensure financing for those centers.

Given the fiscally conservative climate in Washington, DC., states cannot rely on federal grant initiatives, federal protection for cost-based reimbursement, or federal mandates for inclusion of school-based health center programs in Medicaid managed care arrangements. Nor can the states rely on private insurance or other commercial sources to support the centers. The expansion of privately financed managed care and the continuation of ERISA exclusions has eroded opportunities to enlist private dollars in support of school-based health centers. Each state must develop its own approach to supporting the centers. A critical precondition for creating a financial strategy is for each state to address the following basic questions:

- *What is a school-based health center?*
- *Whom should the school-based health center serve if the center is to secure public funding ?*
- *What specific services must be provided?*
- *How will these services be paid for and who (or what) will receive payment for the services?*

This paper discusses approaches to answering these questions.

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Background

Since the first comprehensive school-based health centers were established in the early 1970s, states and localities have increasingly looked to schools as reasonable and innovative sites for assuring access to health care for children and adolescents. Between 1985 and 1992, the number of such programs around the nation grew from 40 to more than 400. According to a national survey conducted by the *Making the Grade* National Program Office, by 1994 there were 607 school-based health centers in 41 states and the District of Columbia (see figure 1, page 6). Nearly half of these programs are located in high schools and over one quarter are located in elementary schools (Schlitt, et. al., 1995). Fueling the recent exponential growth of the centers has been the development of a number of state government initiatives to support school-based health center programs.

At present, most states fund school-based health centers through grant programs that draw from either Maternal and Child Health (MCH) block grant dollars or state general funds. The *Making the Grade* survey found that in school year 1993-1994, 32 states allocated an estimated $38.8 million to local governments or health care institutions to support the centers. Twenty-five states allocated $12 million in MCH dollars to school-based health centers, while another group of 25 states appropriated $22.3 million in general fund support for the centers (see figure 2, page 6). Three states designated funds from the US Department of Education's "Drug Free Schools and Communities" program. Illinois is the only state that commits a portion of its federal Social Services block grant, Title XX, to its school-based health center program. Several states, including California, Florida, Louisiana, Massachusetts, and Missouri, fund their school-based initiatives through special taxes, such as supplemental sales taxes and tobacco excise taxes.

Other major funding for school-based health centers comes from federal grants, private foundations, and local dollars. Since the *Making the Grade* survey, 27 centers have received grants from the federal Bureau of Primary Care. Private foundation initiatives in Connecticut and Michigan are investing an additional $6 million in centers in those states.[1] The Robert Wood Johnson Foundation will provide nearly $18 million for school-based health centers through its national program, *Making the Grade: State and Local Partnerships to Establish School-Based Health Centers*.[2]

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[1] School-based health centers are rarely supported by a single source of funds. In addition to state grants, most centers or their sponsoring institutions pay their expenses through a combination of resources: local health department grants, in-kind contributions from the host schools, support from their sponsoring agencies, and corporate contributions. A number of school-based health centers receive no state grant support. Among the 41 states with school-based health centers, eight states report that fewer than half their school-based health centers receive state support, and eleven states provide no funding to the centers.

[2] Under the *Making the Grade* initiative, 12 states received planning grants to create long-term funding strategies for school-based health centers as well as develop or expand local school-based health center programs. To date, three states, Colorado, Connecticut, and New York, have received implementation grants.

Local support remains vital. All school-based health centers receive help from their host schools; other local agencies contribute varying levels of support. Twenty-three school-based health centers supported by the Robert Wood Johnson Foundation, through its previous grant program the *School-Based Adolescent Health Care Program*, reported that one-third of their budgets were provided in-kind by local sources. In Oregon's Multnomah County, in Fiscal Year 1995, local tax dollars provided $1.4 million or 64 percent of the total operating budget for the ten school-based health centers in Portland.

States that have initiated funding for school-based health center initiatives, in most cases, have asked their health departments to take the lead in program and policy development. In response, the health departments have organized the state grant-making process -- writing the grant application guidelines, developing service standards and quality assurance measures, and determining staffing requirements. Within the health departments an individual or office generally has responsibility for providing technical assistance to local programs as well as facilitating the development of state policies to support the centers.

During the early phase of state support for school-based health centers, the states have considered these initiatives small-scale pilot programs whose characteristics were hand-tailored to fit the small number of communities in which the centers were located. However, as demand for the centers increases and they become part of the state's larger strategy of assuring health care for all children, the policy questions become more complex and require more detailed responses. How should states determine the need for such centers? How can start-up funds for the centers be secured? How will on-going support be obtained? Fundamental premises underlying such questions must be tested: Are the centers to serve all children or only some children? Are there spending priorities for public dollars?

If a state is to assure the availability of school-based health centers as a component of its health care system for school-aged children, the state will need to establish funding priorities by defining where they wish to locate school-based health centers (**targeting criteria**) and by establishing the services the school-based health centers will provide (**service criteria**). This paper reviews possibilities for targeting and service criteria and articulates the financing issues that states must confront as they move to fit school-based health center programs into an on-going, soundly-financed system of health care for children.

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Schlitt, JJ, Garfinkel, S. Where the kids are. State government news 1995; 38(6):20-24.

Schlitt, JJ, Rickett K, Montgomery L, Lear JG. State initiatives to support school- based health centers: A national survey. J of Adolesc Health 1995; 17:68-76.

Fig. 1. School-Based Health Centers, 1985-1994

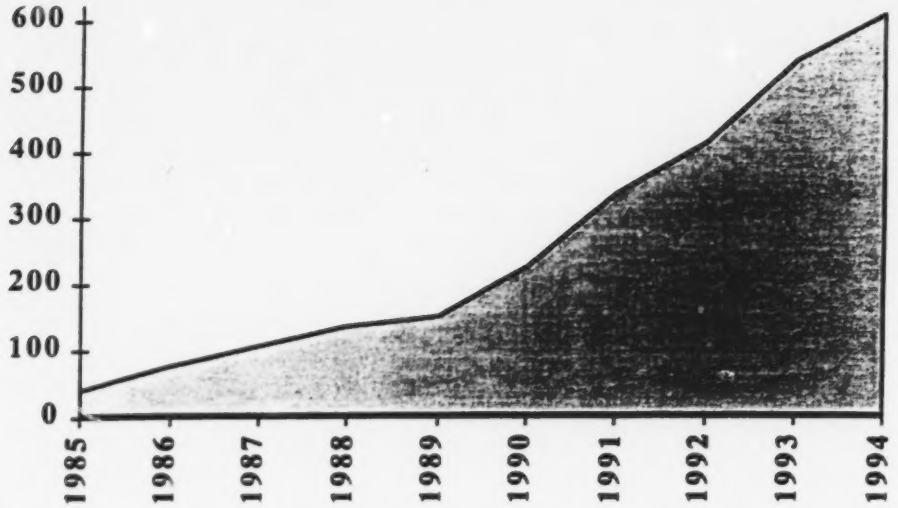
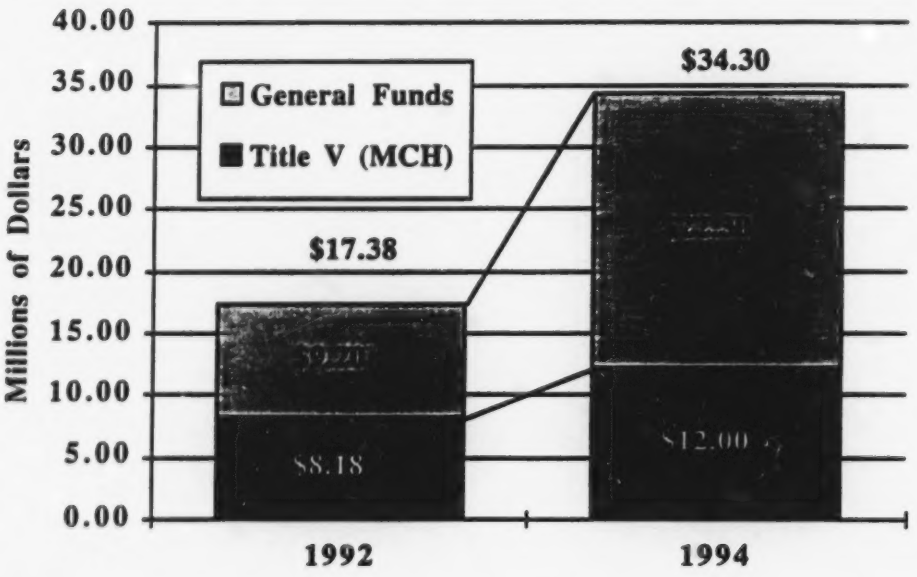


Fig. 2. State Financing of SBHCs, 1992, 1994



Sources:

Figs 1. and 2. Schlitt et. al. State initiatives to support school-based health centers. J of Adolescent Health, 17(2), 1995.

Difficulties in financing school-based health centers through third-party payments

Most school-based health centers have been started and sustained with private and public grant dollars. Funds from patient care reimbursement, whether through private insurance or Medicaid, have only recently contributed measurably to the center budgets (see Table 1, page 8). This limited support from patient care revenues has been due to several factors:

- Initially, school-based health centers were considered experimental projects that were more appropriately funded by grant dollars.

- If privately insured students use the health centers, they are likely to have policies with large deductibles and limited coverage for primary health care and mental health services. While nine states and the District of Columbia have passed the Child Health Insurance Reform Plan (CHIRP), which requires insurers to provide coverage for complete preventive health services for children 0 - 19, to date few health centers are reporting significant revenues from private insurance. The potential gains from CHIRP may be offset by the movement of privately-insured families to ERISA-protected, self-insured plans, which need not comply with CHIRP requirements.

- Adolescents from low-income families are less likely than their younger counterparts to be Medicaid insured. As a result, school-based health centers located in high schools have high rates of uninsured patients (see figure 3, page 9).

- Not all services provided to Medicaid-insured students are reimbursable due to state-specific Medicaid plan limitations or exclusions.

- Because patient care revenue potential is perceived as minimal, many school-based health centers have elected not to bill either patients or their insurers for services provided. These school-based health centers and their sponsoring organizations conclude that the cost of billing would exceed the revenues generated.

Despite barriers to billing, those who organize school-based health centers increasingly believe that patient care revenues are essential to funding the centers. Health care reform discussions have contributed to a perception that in the very near future all personal health services -- even those targeted to low-income students -- will be paid for through a patient care funding mechanism, whether by fee-for-service or pre-paid arrangements. Thus, the critical question: Can these centers fit into the emerging system of health care financing?

The shift from a grants-based strategy towards a greater reliance on patient care revenues is complicated by a concern that a billing or service-focused financing strategy may threaten the unique set of services currently offered by the centers. The centers were established to provide a comprehensive mix of medical and mental health care, health education and preventive services. Health center professionals provide clinical care, sponsor counseling groups, provide classroom education and work with parents, athletic staff and students to encourage a healthier school

environment. Many of these activities are not billable, but most health centers believe these activities are among the most important things they do. To tie the work of the center to a traditional reimbursement system is to risk forcing the health center to alter its package of care from a multi-faceted social model to a medical model of care that de-emphasizes mental health and other less billable services.

Sources:

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Massachusetts Department of Public Health, Bureau of Family and Community Health. School-based health centers: Medicaid standards. Boston, MA: Author, 1994.

Newacheck PW, McManus MA, Gephart J. Health insurance coverage of adolescents: A current profile and assessment of trends. Pediatrics 1992: 90(4):589-596.

Perino J, Brindis C. Payment for services rendered: Expanding the revenue base of school-based clinics. Center for Reproductive Health Policy Research, University of California, San Francisco, Report to the Stuart Foundations, 1994.

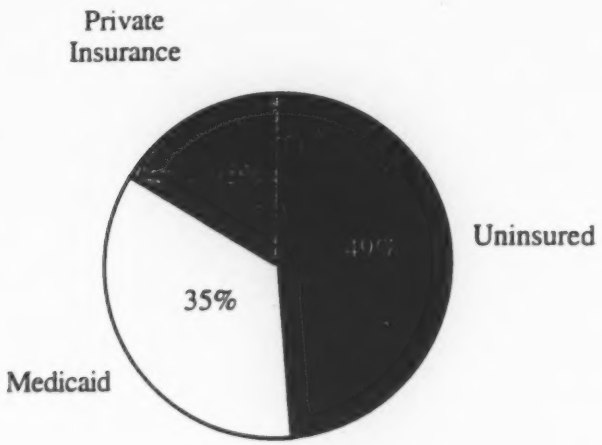
Table 1. Current Funding Sources for SBHCS

State Health Departments	24%
Private Foundations	18%
MCH Block Grants	17%
Local government	12%
School Districts	8%
Community Health Centers	7%
State human services	3%
Title XX (AFL)	3%
Medicaid	2%
Other	7%

Source:

Table 1. Center for Population Options. School-based and school-linked clinics: Update 1991. Author: Washington, DC.

Fig. 3. Health Insurance Status of SBHC Users



Source:

Fig. 3. The School-Based Adolescent Health Care Program. The George Washington University. Washington. DC.

Recent events with major impact on funding strategies for school-based health centers

State and federal governments have utilized a variety of strategies to support health programs targeted on specific populations. These include funding multi-site demonstration programs, establishing preferential payment-for-service formulae, and promulgating rules and regulations that create a favorable environment for the desired services. A number of recent events affect the ability of federal or state governments to use these approaches for the benefit of school-based health centers.

The federal government role in long-term funding strategies is constrained by the collapse of health care reform at the federal level and election of a fiscally-conservative Congress. One component of the proposed Health Security Act that received bipartisan support in both the House and Senate was a section providing for a large-scale federal grant initiative for school-based health centers.[3] Funding for this initiative was to come from cost-saving changes in the plan. Failure of the overall plan eliminated projected savings *and* the likelihood of a large federal grant initiative. The post-election anti-Washington sentiment and the impact of presidential campaign politics on the Congressional legislative process only increases the difficulties confronting federal efforts. As a result, there is increased pressure on the states to solve their own health care funding crises.

States are facing continued fiscal pressures due to explosive Medicaid growth. In the post-Clinton reform environment, states are facing continued Medicaid budget pressures. In five years state Medicaid expenditures more than doubled, growing from $22.5 billion in 1988 to $53.6 billion in 1993 (see figure 4, page 12). Now many state Medicaid offices no longer have the flexibility to initiate or expand innovative access programs, including school-based health care. Congressional proposals to reduce federal public health dollars and curb Medicaid spending either through block grants or federal spending caps will exacerbate the states' financial difficulties.

States are responding to fiscal pressures by developing Medicaid managed care programs. As Medicaid spending has accelerated, politically-sensitive state governments are targeting their Medicaid cost-savings on AFDC clients. These beneficiaries are being enrolled in Medicaid managed care plans, primarily through the creation of Section 1115 and 1915(b) waiver programs that, with HCFA approval, permit mandatory assignment of Medicaid beneficiaries to managed care (see figure 5, page 13). Thus, those school-based health centers that have learned

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[3] Title III (SubtitleG, Part 5) of the Health Security Act called for investment of $100 million in FY 1996 in school-related health services, growing to $400 million in FY 1999 and 2000, with support totaling $1.525 billion over five years. The Education and Labor Committee of the House of Representatives reported out its version of health care reform with a similar level of support for school health services. In its version of Title III, the Senate Labor and Human Resources Committee increased support for school-related health services to $2.35 billion over six years. The Senate committee unanimously approved this section of health care reform legislation.

how to implement fee-for-service billing systems may find themselves unable to collect payment for services because their Medicaid patients are now enrolled in managed care.

Federal eligibility standards for cost-based reimbursement are increasingly restricted and reduce revenue potential for school-based health centers. One method some school-based health centers have used to increase reimbursement from Medicaid has been to enter into contractual relationships with federally-qualified health care (FQHC) clinics. These clinics receive cost-based reimbursement under both Medicare and Medicaid because they serve communities federally-designated as "medically underserved." As FQHC satellite facilities, school-based health centers may receive cost-based reimbursement for care provided to Medicaid beneficiaries. With the federal government facing budget limitations, the identification of communities eligible for "medically underserved" status has become more restrictive. Expansion, and indeed, retention of the FQHC programs is increasingly uncertain as managed care programs have spread. Currently, litigation (NACHC v. Shalala) is challenging the right of the US Department of Health and Human Services to waive FQHC entitlements under Medicaid managed care programs.

School-based health centers have not been defined as "Essential Community Providers" and are therefore not automatically entitled to any special treatment that may be accorded "safety net" services. In an effort to retain cost-based reimbursement for programs targeted on the underserved, a number of health care providers have been identified at the federal or state level as "Essential Community Providers" (ECPs). School-based health centers have not been included in any federal or state definition of "essential community provider," nor are designated essential community providers such as community health centers required to contract with the school-based health centers. Given the legislative and regulatory environment, expansion of ECP designations at the federal and state levels may be difficult.

HCFA appears to be narrowing FQHC and ECP protections. Pending a decision in the NACHC v. Shalala case, the agency maintains that while cost-based reimbursement for FQHC providers is protected under 1915(b) waivers, 1115 waivers give states broader authority to waive all protections for FQHC providers. Moreover, even under a 1915(b) waiver, the state need not protect all FQHCs or ECPs but need only assure that Medicaid beneficiaries retain access to one such provider. Thus, contracts between a school-based health center and a FQHC might *not* assure participation in a managed care plan or cost-based reimbursement.

The Employee Retirement Income Security Act (ERISA) exempts large numbers of employers from complying with state laws regulating health insurance. ERISA, the federal law governing self-insured employers, precludes states from placing any requirements on self-funded health insurance programs, including managed care. Increasing numbers of employers are self-insuring their employees so that nationally almost half of all privately insured workers come under self-insured plans. As a result, there is a shrinking private insurance market from which states might seek support for school-based health centers via sales or other taxes. While school-based health centers may well be viewed positively by the private

sector, ERISA legislation may limit a state's ability to require its participation in school-based health center initiatives or to control how that participation takes place. Cooperation among private insurers, major employers and government agencies may bring about a partnership to support school-based health centers, but the state's role in such efforts at this point appears likely to be advisory rather than directive. Note, however, that the April 1995 decision in the New York Conference of Blue Cross and Blue Shield Plans et al. v. Travelers Insurance Co. et al. may increase the ability of states to finance and regulate health care.

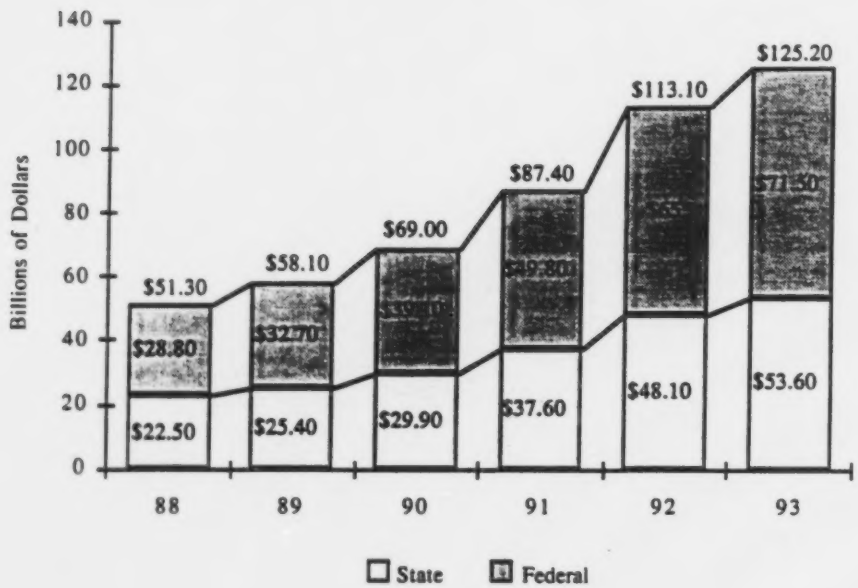
Sources:

Iglehart, JK. Health policy report: Medicaid and managed care. NEJM 1995; 332(25):1727-1731.

National Health Policy Forum, Issue Brief No. 656. ERISA and state flexibility: Exploring options from a state perspective, Fall 1994.

Rosenberg & Associates. Financing adolescent school-related health centers under the proposed National Health Security Act. Author, Point Richmond, CA, January 1994.

Fig. 4. Federal and State Medicaid Expenditures, 1988-93



Source:

Fig. 4. J. Iglehart. Health policy report: Medicaid and managed care. NEJM, 332(25), 1995, 1727-31.

Fig. 5. Medicaid Managed Care Enrollment, 1984-1994

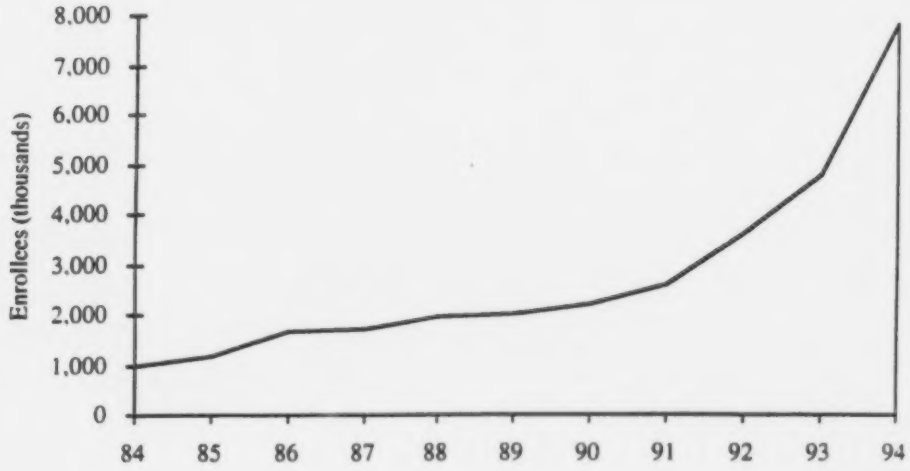
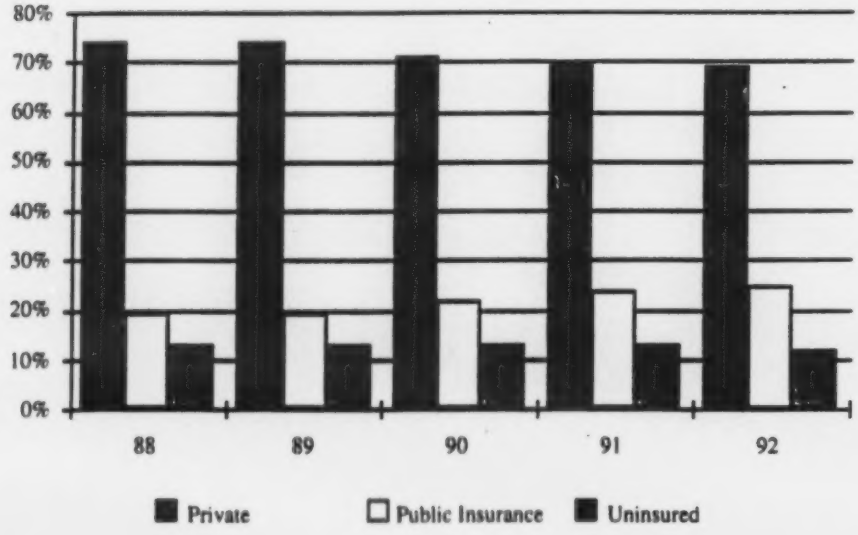


Fig. 6. Health Insurance Status of Children Under Age Eighteen 1988-92



Sources:

Fig. 5. DHHS Health Care Financing Administration, Medicaid Managed Care Office.

Fig. 6. Newacheck et al. Children and health insurance: an overview of recent trends. Health Affairs, Spring 1995, 244-54.

Defining a school-based health center: An essential step towards a financing policy

Because federal Medicaid regulations do not define school-based health centers as participating entities within the program, if a state is to develop special Medicaid-related funding strategies for the centers, the state Medicaid program needs to define the centers as a reimbursable ambulatory care provider-type, that is, a particular health care delivery system unit that can be shown to meet specific standards. Examples of ambulatory care provider types include hospital or health department-sponsored out-patient clinics, federally qualified health centers (FQHC), rural health centers, physicians and physician practice groups, and certified nurse practitioners.

There are advantages, particularly related to reimbursement, to designating school-based health centers as a specific provider type. For example, federal law stipulates that FQHCs and rural health centers (RHC) are entitled to reimbursement for the full cost of providing services to both Medicare and Medicaid beneficiaries. This arrangement allows the centers to include in their payment rate the costs of providing non-medical health services (social work and mental health services, case management, outreach, transportation, community health education, etc.) that are not typically reimbursed in a private medical practice. School-based health centers affiliated with FQHCs and RHCs have the potential for realizing cost-based reimbursement through their sponsor.

States as regulators of Medicaid rate payments can also establish a special reimbursement rate for school-based health centers that, similar to the FQHCs, compensates school-based providers for a broad scope of services to Medicaid beneficiaries. To pursue such a strategy, however, the State Medicaid program must define a school-based health center -- both by identifying the population to be served and by delineating the specific services to be provided.

(1) Options for targeting criteria: defining the communities to be served by state-supported school-based health centers.

Limited resources preclude the expansion of centers into every community that might desire one. Decisions must be made. Priority-setting among communities (i.e. targeting) might utilize one or a combination of the following factors: income, age, insurance status, and health care access.

(a) Low-income

While all school-age children need a broader set of services than is covered under most health insurance, upper-income communities appear more able to finance their own needs. Parents may be more likely to have full-family employer-based health insurance coverage, as well as the time and money to coordinate the different needs of their children. However, working families with low to moderate incomes may have more limited resources, in terms of both time and money. A state may wish to locate centers in those communities with a significant proportion of poor and near-poor households.

A rationale for using low-income as a targeting criterion is that health services research has documented that low income children experience greater health problems than children as a whole.

- Children with emotional or developmental problems are likely to be poor, to have multiple persistent problems, to live in identifiable underserved neighborhoods, and to face particular barriers to needed services (Starfield B, 1992).

- The high child poverty rate in the United States substantially increases the health problems of children. The frequency rates for many medical problems are double to triple the norm among low-income children. Child deaths due to diseases are triple to quadruple those of other children, and low-income children have much greater percentages of conditions limiting school activity, lost school days, and severely impaired vision (Starfield B, 1992).

(b) Age

Age may be used as a targeting criterion to improve health care access for a specifically-defined age group that experiences greater access barriers than other age groups, or may have greater needs. Historically, adolescents ages 10-19 have been a primary target group for school-based health care because national data suggest that, as a whole, adolescents are less healthy and utilize health services less frequently than their pre-adolescent peers.

As more communities place school-based health centers in elementary schools, states must carefully assess the political ramifications of targeting populations generally thought to be less in need and better served by traditional health care systems.

Some of the data confirming the health needs of adolescents are as follows:

- At least 20 percent of adolescents have one serious health problem. These include visual, auditory and dental problems that can seriously impede the ability to perform well in school. Many adolescents also suffer from a diagnosable mental disorder (Office of Technology Assessment, 1991). Mental health problems increase with age: while 12.7 percent of 6-11 year olds are reported as having emotional or behavioral problems, 18.5 percent of 12-17 year olds have these same problems. The highest frequency of problems is reported among males ages 12-17. The most common problems include attention deficit disorders, phobias and anxiety disorders, depression, and learning disabilities (Zill and Schoenborn, 1990).

- In addition to chronic physical and mental health problems, adolescents have experienced some striking increases in behavior-related problems. Suicide and homicide rates have tripled among young people aged 15-19. One in five adolescents acquires a sexually-transmitted disease by age 21, and teen pregnancies continue at a rate of one million teenage girls becoming pregnant each year (Lear, 1995).

- Mainstream delivery systems are not geared to adolescents. Adolescents present special problems to caregivers given that their care needs to be confidential, convenient, comprehensive and age-appropriate (Office of the Inspector General, 1993).

- Adolescents see office-based physicians less frequently than other age groups (Klein et al, 1992).

- Many primary care physicians do not feel comfortable with adolescents, who are seen as not fitting into a pediatric or an adult care model (Klein et al., 1992).

- Young people are often "of the moment." They are likely to seek care at the time it is needed. If medical attention must be scheduled at a later time, a broken appointment is likely to result (Office of the Inspector General, 1993).

- In many states, Medicaid and other public assistance programs cover few adolescents.

- Uninsured adolescents are reluctant to burden financially-struggling families with health care costs (Feiden, 1993).

(c) Insurance Status

As employer-based health insurance declines and children of working parents become increasingly less likely to be insured, states may choose to target communities with significant numbers of uninsured school-age children. Recent publications have documented the increased numbers of uninsured children and the implications for health care access:

- An article in the New England Journal of Medicine showed that uninsured children aged 6-17 were significantly less likely to see a physician for four common conditions for which medical care is considered necessary (pharyngitis, acute earache, recurrent ear infections, and asthma), even when socioeconomic conditions were taken into consideration (Stoddard et al., 1994).

- Children's employment-related insurance coverage declined from 64.1 percent in 1987 to 59.6 percent in 1992 (Teitelbaum, 1994).

- Lack of health insurance crosses boundaries of race, family status and family income. In 1992, almost 8.3 million children were uninsured for the entire year, of whom 6.4 million were white (12 percent of all white children), 1.4 million were black (13.5 percent of all black children), and about 2 million were Latino (25.7 percent of all Latino children, noting that persons of Latino origin may be of any race) [Teitelbaum, 1994].

- In 1987, most uninsured children lived in poor or near-poor families. Almost half of children from families with incomes below the federal poverty level (FPL) was uninsured for all or part of the year; almost 35 percent of children in families between 100 percent and 200 percent of the FPL was uninsured for all or part of the year (Monheit, 1992). In 1991, the highest percentage of uninsured children was from families with incomes between $10,000 and $19,000 (Kogan, 1991, cited by Teitelbaum).

d) Inadequate primary care access

Barriers to ambulatory care due to inaccessible or limited numbers of primary care providers may constitute another criterion for community selection. Evidence of access problems for school-age children have been reported in leading medical journals.

- Investigations by the United Hospital Fund in New York City, which reports on City programs providing innovative AIDS and health care services to high-risk adolescents, indicate that adolescents have problems in accessing care in underserved areas (Feiden, 1993).

- Hospital admissions in New York City for ambulatory care-sensitive conditions, which suggest inappropriate emergency room utilization and inadequate primary care availability, are significantly associated with area and income for children aged 6-17 (Billings et al. 1993).

- A recent article in the New England Journal of Medicine by the Medicaid Access Study Group points out that for Medicaid beneficiaries, obtaining ambulatory care outside of emergency rooms is difficult (Medicaid Access Study Group, 1994).

In summary, it might be argued that the children for whom school-based health centers are most useful are adolescents, ages 10 - 19, from low-income families. Many of these young people are without health insurance, and even for those who have Medicaid or some other form of coverage, access to care may be limited by social conditions including the absence of appropriate providers in their community. In addition, the range of care for chronic physical, mental health and behavioral conditions, and the social support to help them manage ongoing problems, is not routinely available through existing health care provider organizations.

States will likely have many more needy communities than can be served by a state-sponsored program. Therefore, it may be important for a state to add additional criteria, such as community support or evidence of parental leadership. States may also choose to rank-order communities in terms of variables such as the availability of local matching dollars, or the perceived likelihood of success. The viability of a state-sponsored school-based health center program will be significantly enhanced by the development of explicit criteria for the kinds of needy communities where the program is most likely to be effective.

(2) Defining school-based health center services

To determine the costs of operating a school-based health center as well as to lay the groundwork for discussions with managed care plans, states must define the required components of school-based health care and identify standards for how services are to be rendered. The School Health Policy Initiative at Montefiore Medical Center, in collaboration with groups of national experts, has developed both a set of operating principles for school-based health centers and an outline of recommended services to be provided by the centers (Brellochs, 1995).

Service criteria typically include a statement of program objectives. An example for a school-based health center might be: "to assist students to function appropriately in their social and educational environment by meeting their physical, social and behavioral needs in a comprehensive primary care center with-in a school-based health program." Services to achieve this objective can include:

- preventive and primary care, including health education.
- diagnosis and treatment of illness and injuries, including referral to linked partners, follow-up care, and longitudinal management of chronic problems.
- limited on-site laboratory capability;

- radiology service through linked providers.
- access to appropriate mental health resources.
- behavioral health care and social support.
- coordination of health and educational concerns.

State standards for school-based health centers are spelled out in documents supporting a number of state grant initiatives. While state Medicaid programs have not yet become involved in the definition of school-based health centers, state health departments have become increasingly so. In the process of initiating grant programs for school-based health centers, the health departments have established program goals, described service and staffing standards, and defined prototypes for replication. Of the 50 states surveyed by the Making the Grade National Program Office, 22 have established state school-based health program guidelines, ranging from suggested to mandated program standards (see Table 2 below). Twelve of these standards, judged by the Program Office to be well-defined and comprehensive, are summarized in the appendix. Nine states reported that program guidelines were under development. With few exceptions, states define school-based health centers as vehicles for coordinating and delivering accessible primary physical and mental health services to students. The states' definition of required or desired services are fairly uniform. The services to be provided include: preventive health care, acute care, routine examinations, immunizations, social services, health education and mental health counseling. Reproductive health services are more frequently suggested than required for centers serving older students. What becomes clear from conversations with state officials is that the process of defining the school-based health center service package is difficult given the value attached to a strong programmatic role for local officials and community groups. Extensive discussions involving a mix of state and local representatives are essential to establish consensus on the service package (Schlitt JJ, et al).

Table 2. State Guidelines For School-Based Health Centers[1]

Required/Suggested Guidelines[2]		In Development[3]	No Guidelines[4]	
Colorado	Michigan	Arkansas	Alabama	Nevada
Connecticut	Nebraska	Iowa	Alaska	New Hampshire
Delaware	New Jersey	Maryland	Arizona	North Dakota
Florida	New Mexico	Missouri	California	Oklahoma
Georgia	New York	Rhode Island	Idaho	South Carolina
Hawaii	North Carolina	Tennessee	Kansas	South Dakota
Illinois	Ohio	Utah	Kentucky	Washington
Indiana	Oregon	Vermont	Minnesota	Wisconsin
Louisiana	Pennsylvania	West Virginia	Mississippi	Wyoming
Maine	Texas		Montana	
Massachusetts	Virginia			

1 With many states developing new school-based health center initiatives and other states assessing and re-assessing their preferred models, all state guidelines might be considered "works in progress."
2 States in this category have either issued guidelines which must be complied with as a condition of state funding or have developed guidelines that are recommended to communities but are not a requirement for funding.
3 Some states that have funded school-based health centers using general guidelines are now clarifying their service standards and staffing requirements. These states are moving towards an explicit comprehensive model. A number of states are elaborating several models for health services in school, ranging from limited services to comprehensive health centers. States that have recently funded school-based health centers are developing their initial standards by drawing upon the experience of older programs.
4 States that have not developed guidelines for school-based health centers either do not support centers or have a total commitment to local control.

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Strategies to fund school-based health centers: Alternative reimbursement models.

Once the state has defined a school-based health center provider-type by identifying the community to be served and the services to be provided, the state must then address how the school-based health centers will be paid for their services. In so doing, the distinction between local and state perspectives must be considered. The individual school-based health center or its sponsor is responsible for covering its operating costs; the full range of alternatives from contracts with managed care plans to fee-for-service billing to categorical grant initiatives and in-kind contributions must be explored. Regardless of its creativity and energetic pursuit of financing, however, the health center's access to financial support will be determined, in great part, by decisions at the state level.

The level of state support for school-based health centers is a function of the combined decisions of all the state agencies that agree to participate in supporting care provided by the centers. It is therefore important that the broadest range of decision-makers sit at the table when determining what resources can be applied to school-based health centers. In general, the key participants will include the Medicaid director, the Commissioner of Public Health, the Superintendent of Schools, the Commissioner of Mental Health and, perhaps, the Insurance Commissioner. If special health care reform offices have been established, their involvement is essential as well.

To assure stable long-term financing for school-based health center programs, resolution of the following issues is critical: Should payment to the centers be on a fee-for-service basis? How are uninsured students to be covered? How can this program fit with managed care? Should state-supported programs be paid only through Medicaid, and if so, should they serve only the Medicaid-eligible population? Experience has shown that whichever model the state chooses to adopt must be accepted and supported at every level of state government.

There are a limited number of approaches for paying school-based health centers for the care they provide to designated populations. These include a regulatory approach, a market approach, and a "pooled fund" approach.

A regulatory approach

Under this approach, the state through its regulatory process defines the school-based health center provider-type, including the establishment of targeting criteria and services to be provided, and mandates that Medicaid managed care plans (and/or potentially all licensed insurers in the state) pay the provider-type for services provided to their enrollees at a stipulated rate determined to cover the costs of providing that care.

This approach is not dissimilar to some existing provisions under managed care. For example, family planning services are often "carved out" from the primary care contracts of Medicaid managed care providers. That is, although family planning is a covered benefit for which the managed care plan is responsible, enrollees may obtain family planning services outside the plan without going through their

primary care "gatekeeper." The managed care organization excludes family planning services from the per capita payment to the primary care provider, and pays the family planning organization on a fee-for-service basis. This is done because all parties want enrollees to have free access to family planning services, which would be less likely to occur if pre-approval were needed from the primary care gatekeeper.[4]

The regulatory approach has several benefits: it provides stable funding; it defines and codifies the school-based health care model; and it allows the state to determine the scope and breadth of the program. It also fits well within the traditional role of government in serving the low-income population. The necessary technology exists to implement the approach, since the centers will be serving in an established role, that is, they will operate as vendors to managed care plans.

There are also drawbacks: The percentage of school-age children for whom a school-based health center would receive payment under such an approach must be carefully assessed. Because states may lack adequate regulatory authority over self-insured plans (approximately half of all insured employees and dependents are insured through self-insured plans), the financing of school-based health centers will be largely dependent on Medicaid and other insurance plans regulated by the state. If only a small number of students are covered under Medicaid and other state-regulated plans, funding for the centers from this source will necessarily be limited.

From the perspective of the school-based health center, the regulatory approach calls for considerable administrative effort. The center will need to identify the managed care plan in which the student is enrolled (in general it is the parent, rather than the child, who is the direct enrollee, making identification sometimes very difficult). The center must then obtain all necessary billing numbers and generate a bill that meets the needs of the managed care plan. The problems faced by Medicaid managed care programs in managing the Medicaid population will be passed on to the center, and are likely to become magnified in the process. Notification of plan enrollment change by the parent may not be accomplished smoothly, and the problem of eligibility may become even more difficult. Representatives of Medicaid managed care plans complain that their greatest problem arises from involuntary disenrollment through loss of eligibility, which often affects 50 percent of their covered population annually.

Other complex problems may arise in a Medicaid managed care plan, including possible limitations on mental health services providers, and an unwillingness to reimburse for services of clinical social workers, who often play a major role in school-based health care. Moreover, the managed care plan may limit the number of outpatient mental health visits, or may require (as in New York State) that after 10 such visits the patient's care is shifted to a mental health managed care provider.

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[4] By a 1986 amendment to Title XIX of the Social Security Act, Congress "carved out" family planning from the Medicaid managed care programs under the 1915(b) waiver process to assure that Medicaid beneficiaries had broad access to family planning services. However, the carve out is not applicable to Medicaid managed care programs operating under Section 1115 waivers. See P.L. 99-509, Section 9508. Sara Rosenbaum et al., Beyond Freedom to Choose: Medicaid Managed Care and Family Planning, Center for Health Policy Research, The George Washington University, Washington, DC.

Lastly, to participate efficiently within a managed care system, school-based health centers will need medical billing capability and full understanding of the complexities of health care accounting practices.

A market approach

Under the market approach, rather than identifying and certifying the school-based health center as an essential provider-type, the state would define the function of the school-based health center as an essential *service*. That is, the state would specify that if a managed care organization is authorized to serve an area with more than a certain percent of Medicaid enrollment, it must provide school-based health care services as part of its Medicaid contract.

Using this approach, it would be possible for managed care organizations to work collaboratively with community schools to ensure a sound, well-organized program. Collaboration, however, is by no means guaranteed. Several centers might be organized by competing plans in schools that are in close proximity to one another. Will the centers serve students who are not enrolled in the sponsoring plan? Indeed, there are a number of potential problems, including neglecting the sensitivities of the school itself. Some schools may not want a center either for political reasons or due to space scarcity. The issue of governance is also likely to be problematic: who would own the center and could it be owned by one plan, or by several together?

The question of accountability also arises. To whom would the managed care organization be accountable, and for what? Could students vote with their feet and obtain services elsewhere? Hypothetically, unless the managed care organization is held accountable for the services it provides via school-based health center standards, the plans may find it in their best interest to limit resources and make the program extremely unattractive. Without accountability, there will be limited acceptance of responsibility for the needs of the student, and an idiosyncratic program may well develop.

A "pooled fund" approach

Under the pooled funding approach, the state assumes direct responsibility for the program, and funds it via a global budget paid directly to each center. The state determines the centers' operating cost and creates a fund to pay for a specific number of centers by pooling money from a variety of sources. These include Medicaid funds obtained under 1115 waivers, federal maternal and child health funds, state general revenue support, foundation grants, and other related funds available through education and human services. By the state pooling these funds together, matching federal Medicaid funds under the terms of the 1115 waiver could be obtained. The project could then be administered by an appropriate state agency in accordance with defined targeting criteria and service levels as previously discussed.

In 1991, the New York legislature considered a variation of this approach. As reported by Christel Brellochs, proposed legislation sought "to take advantage of disproportionate share allowance provisions of the federal Medicaid program by designating the $3 million in State funds allocated to school-based health centers as the state contributions to Medicaid. If this amount were matched by local (25%) and federal (50%) shares, approximately $10 million would be generated for the school-based health centers. Combined with the Title V allocation of $3.5 million.

a total of $13.5 million would be available to fund school-based or school-linked services." The proposal was rejected by the New York Senate as a result of end-of-session politicking, but the New York experience suggests the possibility of this approach (Brellochs, 1992).

The model, however, has not been implemented in any state. As a result, there are a number of issues that will need to be resolved. The state must be able to monitor the management of global budgets by the centers to assure efficient operation. Incentives for optimum utility must be incorporated so that if a center's utilization rate is lower, it receives a smaller budget. At present, there are limited data available to inform the establishment of an appropriate budget based on utilization (that is, we don't currently know, in a high school of, for example, 1,000 students. what the normative budget for a school-based health center should be, or what might impact on that budget in terms of making it larger or smaller).

A major attraction of this approach is that currently-available funds, such as the Maternal and Child Health block grant program and private foundation grant awards such as those from the Robert Wood Johnson Foundation, the Kellogg Foundation, and the William Caspar Graustein Memorial Fund could be used to learn more about how to organize this kind of program and manage global budgets efficiently. It would then be possible to "carve out" the services and finances from state-sponsored Medicaid managed care programs, and continue the program as a direct state-supported operation with an appropriate global budget. The learning period could also be used to continue to build solid community support for the program. This includes working with the schools to assure their perception of ownership and working with community providers to develop sound referral relationships, an essential requirement for collaborating with managed care programs.

It seems as if we can see the future for school-based health center programs, as for all other health care endeavors, only in a glass darkly. Nonetheless, it seems possible that this kind of globally-budgeted program, funded by the state through pooling a variety of resources, may provide a sound interim step in learning not only how to fund the program for the longer term, but also how to implement it effectively through well-developed targeting and service criteria.

A comparative analysis of the three long-term financing approaches is summarized in Table 3 on the next page.

Table 3. Alternative Reimbursement Models For State-Sponsored School-Based Health Center Programs

	Regulatory Model	Market Model	Pooled Fund
Accountability	Must meet state-defined criteria	Unclear	Managed by state dept. of health
Payment Mechanisms	State-stipulated per-unit rate (fee-for-service)	Determined by market	State-determined global budget
Administrative Burdens	High for all parties: state, centers and managed care plans	Low for states; market determines for managed care plans	Mid-level for states; minimal for centers and managed care plans
Student Evaluation	Choice limited to enrollment opportunities under Medicaid managed care	Unclear	State accountability process must include student assessment

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STATE GUIDELINES FOR SCHOOL-BASED HEALTH CENTERS, 1994

	Primary Goal	Sponsoring Agency	Site Specifications	Service Definitions	Staffing	Community Participation	Parental Consent	Continuum of Care	Evaluation & Quality Assurance
COLORADO	To remove financial and organizational barriers that inhibit establishing and sustaining school-based health services which will ultimately facilitate universal access to basic primary preventive physical and mental health care services for the school-age population.	Ideally, SBHCs will be linked with Community Health Centers, local health departments, and county nursing services which are permitted reimbursement without a physician on-site.	Located on the school site.	Varies based on school type: Elementary: well child care; Middle school: well child/ adolescent care, reproductive health, and optional contraceptive services; High school: well adolescent and preventive health services and substance abuse services. All centers offer acute care, lab tests, meds, acute care for chronic conditions, dental care, mental health, and health education	Guidelines suggest school nurse practitioner or physician assistant, mental health practitioner, student health technician (or secretary), and health educator; At the middle and high school levels, substance abuse and violence prevention specialists may be added.	Must provide evidence of relationships with public and private health providers, teachers, school health personnel, community-based organizations, service clubs and other community groups, parents, students, and others determined to have a stake in the health of the community's children.	Parents should be allowed to choose whether their child may use the SBHC services by having the option to sign a consent form.	Case management and follow-up to ensure that all health concerns are adequately addressed; After hours coverage and linkages with all appropriate levels of care is required.	Information on the quantity and quality of services delivered will be collected by sites using School HealthCare On-Line!!; Data and outcome accountability requirements will be defined.
	Source: *Making the Grade Application, 1993 and Quarterly Report, 1994.*								
CONNECTICUT	To expand comprehensive health services for school aged children and adolescents.	A medical provider who delivers services at the community level will be selected by the community advisory board based on ability to meet state agency and RWJ model requirements, willingness to form a partnership with the school system, and ability to meet state licensure standards for an out-patient clinic.	On-site availability of adequate clinic space is mandatory. The SBHC should be located in a fairly visible area of the school. It must be made appealing to the students, both in terms of aesthetics and accessibility. The center must be designed to ensure privacy and confidentiality and meet state licensing standards.	Primary health care, social services, mental health, health education, prenatal and post-partum referral and follow-up; Encourage dental services where need is indicated.	Includes a center manager with training in mental health/health systems management, at least one nurse practitioner with adolescent health experience, one MSW with consultant backup, additional allied health professionals as needed, and clerical support.	Linkages to the community medical and social service providers (local health departments, community health clinics, medical schools/hospitals), must be established and maintained.	Parental consent is required to receive center services	Must define back-up for center non-operating hours and linkage to services beyond clinic scope through letters of agreement. Ideally, the center staff would have privileges at the back-up site(s) in order to enhance the continuity of care.	Both components are site specific and site-determined; Plans and outcomes are monitored by state department of health services.
	Source: *Standard Model for School-Based Health Centers, CT Department of Health Services, 1993*								

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STATE GUIDELINES FOR SCHOOL-BASED HEALTH CENTERS, 1994

	Primary Goal	Sponsoring Agency	Site Specifications	Service Definitions	Staffing	Community Participation	Parental Consent	Continuum of Care	Evaluation & Quality Assurance
DELAWARE	Provide primary prevention and early intervention for health problems among the student population; Assure that each student has a medical home.	Health care delivery organization; Local school district and board of education must approve the project's planning and implementation.	Open 5 days a week and operational year round (with provisions for reduced summer hours).	All service components will be approved by local school board based on needs of student population; Services to be provided include medical health assessments, diagnosis and treatment, social services, health and nutrition education, and community service referral; STD and HIV services may be provided; reproductive health care is prohibited.	Recommended core staff: nurse practitioner, with physician back-up, a minimum of 3 days a week; physician available a minimum of 2 days a week; masters prepared social worker a minimum of 2 days a week; nutritionist a minimum of 1 day a week; clerical support on daily basis; one project coordinator (may be the responsibility of professional staff). School nurse serves as link between the center and the school.	Local advisory council for both planning and implementation is required.	Written parental permission required prior to providing medical services.	Plans for provision of services during non-operational hours and reduced hours during summer months must be clearly identified; Memoranda of understanding required for referrals, support services and 24 hour coverage; Referral network / plan between family physician, HMO, or other medical group must be stated.	State public health division serves as manager to assure compliance with accepted model and standards. Programs are required to participate in School HealthCare On-Line!! data collection system.
LOUISIANA	Meet the physical and emotional health needs of adolescents at schools.	Shall be private or public institution locally-suited for administration / operation of SBHC; (i.e., health center, hospital, medical school, health department, youth serving agency, school or school system); Non medical agencies must contract medical component with qualified medical provider.	Must function as integral component of school(s) and work cooperatively with school nurses, classroom teachers, coaches, counselors, and school principals; Local grantees are subject to 20% financial match; Must become a Medicaid provider.	Should include but not limited to: preventive health care and medical screenings, treatment for common simple illnesses, referral and follow up for serious illness and emergencies, mental health, alcohol and drug abuse services, immunizations, and preventive services for high-risk behaviors such as pregnancy, STDs, drug and alcohol abuse, violence and injuries.	Should include, at a minimum: a nurse (or nurse practitioner or physician assistant), one or more part-time physicians, a social worker or mental health professional at least part-time, and a medical office assistant. The school nurse should work with the SBHC personnel to develop health education messages.	Must provide evidence of planning process involving a broadly representative community group; Must form community advisory board.	Must assure parents execute written consent form approved by school authorities.		Required to submit plan for monitoring and evaluation Required to participate in School HealthCare On-Line!! data collection system.

Source: *Report on School-Based Health Centers in Delaware, Delaware Health and Social Services, December, 1993*

Source: *Adolescent School Health Initiative Request for Proposals, 1992*

STATE GUIDELINES FOR SCHOOL-BASED HEALTH CENTERS, 1994

	Primary Goal	Sponsoring Agency	Site Specifications	Service Definitions	Staffing	Community Participation	Parental Consent	Continuum of Care	Evaluation & Quality Assurance
ILLINOIS	Improve the overall physical and emotional health of students.		May be in or adjacent to a school... A minimum of two examination rooms is desirable; State provides specs for clinic equipment and lab utility room.	...devoted primarily to performance of preventive medical, educational, counseling and/or diagnostic procedures; May include routine medical care, exams, lab screenings, STD and reproductive health services.	Minimum staff shall include a medical director (primary care physician), a registered nurse, a school nurse, and a clerical support person; May include OB/GYN, ARNP, RN, school counselor, and/or dentist.	Each clinic shall have an advisory board consisting of school administrators, medical community, school nurse, parents, clergy, youth agency reps, community leaders; Shall have a written plan for community involvement.	Must provide parental consent form including description of the clinic, scope of services offered, and option to select which services are to be provided.	To further broaden resources, school-based clinics should link services with other health and social services in their area. A communication system for emergency and non-emergency services referral shall be available during non-clinic hours.	Internal review team is responsible for continual monitoring of services; May be performed through random sample of monthly chart audits; Service standards must meet those of AAP and ACOG.
	Source: *School Based Health Clinic Guidelines, Illinois Department of Public Health*								
MAINE	Establish strong community, school, and parent support and involvement in SBHCs; to assess and evaluate the health care needs of the students; to coordinate delivery of comprehensive primary health care within an educational framework and school setting, to monitor the health care provided to students; and to evaluate the health status of students by specific outcome criteria.	Eligible sponsor includes school system or medical provider.	Must be convenient and centrally located to the students. Space must be adequate in size to provide sufficient room for a waiting area and privacy for physical examinations and counseling. Space is required for laboratory services, equipment, secure storage for supplies, and placement of records. The floor plan should be about 2600 gross square per 4000 school population.	Core services determined by community indicators include physical exams, diagnosis and treatment of minor injuries and illnesses, immunizations, EPSDT screenings, lab tests, chronic illness management; and pediatric care of students' infants. Dental, reproductive and mental health primary care services may be offered but are not required.	Recommend nurse practitioner or physician's assistant, physician consultant, a counselor or social worker, and receptionist. The school nurse should be serve as liaison on the advisory committee and assist in program development. Other allied health professionals should be part of the center staff as needed (e.g. nutritionist, psychologist, clinic assistant).	A community-based advisory council should include consumer and provider groups, professionals with special skills, community groups with clout, school administration, school staff, students and others.	Parental consent form must be signed, returned, and on file in order for a student to receive all or indicated center services.	Medical consultant or provider group will be available for follow-up services after hours.	Participate in School HealthCare On-Line!! Primary outcome indicators include mental health status, chronic or acute illness, injuries, nutritional problems, pregnancy, drug and alcohol abuse, and tobacco use. The state conducts site visits and provides instructional workshops. Periodic chart reviews are conducted to assure adherence to protocols and policies.
	Source: *Developing a School-Based Health Clinic, An Assistance Manual, ME Department of Human Services, 1992*								

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STATE GUIDELINES FOR SCHOOL-BASED HEALTH CENTERS, 1994

	Primary Goal	Sponsoring Agency	Site Specifications	Service Definitions	Staffing	Community Participation	Parental Consent	Continuum of Care	Evaluation & Quality Assurance
MASSACHUSETTS	Ensure that children and adolescents will have access to early, comprehensive and competent health care.	Joint venture between primary care provider (e.g., community hospital, neighborhood health center) and host school; Health care provider serves as lead agency; Must have formal agreement with host school district.	Must demonstrate a floor plan for clinic location; Must be licensed by state health department; Must be accessible for outreach and after-school and summer use.	Must offer comprehensive primary care. Service elements include: screening and assessment, preventive health services, exams, diagnosis and treatment, health education, substance abuse services, mental health services, and reproductive health.	Under medical supervision of physician; On-site staff must include one of the following: physician, nurse practitioner or registered nurse; Must also include a student health services coordinator to serve as case manager. The SBHC program is meant to enhance the existing school nursing staff.	Shall establish an advisory committee with student representation.	Written parental consent, usually obtained at beginning of school year, is required for all services except those deemed emergency;	Shall include strong referral systems to ensure students receive a continuum of health care; A linkage plan should be established with clear identification of what will be provided on site and what will be referred; Must be able to offer 24 hour back-up.	Must participate in statewide SBHC data collection system; Must use standardized registration and encounter forms to provide core data set; State health department conducts periodic site visits to monitor quality.
	Source: *School Health Services, Request for Proposals, MA Department of Public Health, August, 1993.*								
NEW YORK	Bring direct access to comprehensive primary and preventive health care to medically-underserved children.	Provider must be certified under the public health law or be a private and/or group physician licensed to practice medicine in New York; Must enter into a memorandum of understanding with school, school district or board of education.		Clinics must provide: mass screening services, physical exams, health and psycho-social counseling, diagnosis and treatment of medical conditions both acute and chronic, immunizations, lab tests, and reproductive health care on site or by referral.	Providers must be mid-level practitioners with physicians as supervisors; Must meet state DOE requirements for professional licensure and experience; Additional staff may include social worker, psychologist, and nutritionist.		Parental consent is required unless student is 18 years or older, or otherwise qualified to give consent.	Must agree to provide follow-up services for children in need of health care who lack a primary care provider; Requires linkage with hospital or diagnostic and treatment center for 24 hour, 7 day-a-week continuous comprehensive care.	Required to participate in School HealthCare On-Line!! data collection system; Required to participate in statewide quality assurance program, Program Effectiveness Review Tool (PERT)
	Source: *Requirements for Non-Funded Chapter 53 School Health Demonstration Projects*								

STATE GUIDELINES FOR SCHOOL-BASED HEALTH CENTERS, 1994

	Primary Goal	Sponsoring Agency	Site Specifications	Service Definitions	Staffing	Community Participation	Parental Consent	Continuum of Care	Evaluation & Quality Assurance
NORTH CAROLINA	Increase students' access to health care; Provide early identification of health problems and on-going treatment and prevention of disease and injury; Encourage students to take personal responsibility for their health care.	In cases where applicant is not a health services institution, a qualified medical provider must be identified to contract for the delivery of medical services; Letter of commitment from superintendent and board of education required.	Primary site must be located within the school setting and operate full time while school is in session.	Must be comprehensive in nature, including primary care, mental health, preventive health care and health risk reduction services. Must interface with existing health and human services and resources in the school.	Must be provided by a multi-disciplinary team including nurses, physicians, physician extenders, clinical social workers and nutritionists; At a minimum, on-site staff must include a registered nurse (this may be the school nurse), nurse practitioner/ physician's assistant with physician back up, mental health professional, and clerical staff.	Must be governed in concert with formal community advisory board comprised of parents, community leaders, health care providers, and youth agency representatives for the purpose of planning and oversight; Must demonstrate high degree of community ownership and support.	Must assure that no student will receive services without a written parental/ guardian consent form on file.	Must clearly identify plan for provision of services when the center is not in operation to assure continuity of service delivery and a continuum of care.	Must establish criteria for evaluation and measuring success and impact expressed as process and outcome measures; Required to participate in School HealthCare On-Line!!
	Source: *Grant Announcement, Request for Proposals, NC Dept. of Environment, Health and Natural Resources, 1994*								
OREGON		All sites will establish a partnership with the local school district and the local health department; Other partnerships may include: psychologists, social workers, public and private health care providers, family planning clinics, and hospitals.	On the school campus.	A model center will provide accessible, comprehensive, culturally-sensitive services to students, including age-appropriate physical and mental health promotion, prevention, intervention, and treatment services. Referrals to appropriate sources will be made for services that cannot be provided on-site.	One full-time nurse practitioner or physician's assistant, an MD as medical director and consultant, nurse with adolescent experience, clinical social worker, a drug and alcohol specialist, and a receptionist and/or health assistant. Other allied health professionals as needed.	Must demonstrate evidence of community input from parents, teachers, students, health care providers, business leaders, managed care and private insurers, and community religious leaders for SBHC planning and implementation The SBHCs will collaborate with the school district parent-teacher organizations, and the local school site to establish SBHC role within the school system.	Students aged 15 and older can consent to receive health care services and persons of any age can obtain family planning and STD related services without parental consent. Some local communities have developed enrollment policies that require parental consent for specific services.	Provide integrated services to decrease fragmentation and assure that students receive care and guidance. At the local level, 24-hour coverage must be provided by a community health care provider/ sponsor.	Chart audits of presenting problems and problem resolution are suggested by the State. Site visits are conducted by the state through the county health departments every two years. State Health Division Annual Report is produced annually with data collected by the SBHCs.
	Source: *Making the Grade Application, 1993.*								

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STATE GUIDELINES FOR SCHOOL-BASED HEALTH CENTERS, 1994

	Primary Goal	Sponsoring Agency	Site Specifications	Service Definitions	Staffing	Community Participation	Parental Consent	Continuum of Care	Evaluation & Quality Assurance
PENNSYLVANIA	Improve the health status of children through the expansion of health services currently available in selected pilot schools and improved integration of school health services within a community-based primary care system.	School districts serve as the lead agency in coordination with the community-based primary health care system.	On the school site.	Must provide a package of primary preventive, child/family health services including physical assessment, immunizations, growth measurements, developmental and behavioral screening, clinical screens, routine cultures and lab tests, child/family health education services, and referrals for specialty care.	Require certified registered nurse practitioner, physician's assistant or physician. School nurse involvement is encouraged. School nurse may serve as the center manager.	Encourages the involvement of other community-based health and social services providers in program planning and implementation.	Require written parental consent for all enrollees.	Provide care coordination for follow-up and referrals; assist in accessing needed health, social, nutritional or other services; track referrals to determine service status; conduct home visits when necessary; guarantee assurance of 24-hour on-call services and consultation for referral of problems not treatable on-site.	Require collection of encounter and enrollment data to participate in statewide evaluation system; Assure mechanisms are in place to evaluate the quality and appropriateness of patient care.
	Source: *Request for Application, School-Based Primary Health Services Pilot Projects, 1992.*								
TEXAS	Establish collaboration of families, schools and community; Assure medical home for student; Provide access for specialized medical care; Promote health and use of health systems.	Eligible providers may be civic or charitable organization, community health centers, public health agencies, hospital districts, school districts, medical schools, or private providers; Full support of school district must be evident.	At a site on or near school grounds.	Core services, which must be made available, include: maintenance of health record and health plan, screenings, exams, immunizations, diagnosis and treatment of simple illness and minor injuries, education and counseling, and mental health.	May be scheduled full or part-time: physician/medical director or an appropriately trained licensed nurse practitioner under physician direction, mental health counselor; social worker, registered nurse, and clerk. The existing school health personnel and the SBHC staff work as a team.	Advisory council of parents, youth, churches, youth and family services, physicians, nurses, and other health care providers, business, school nurses, school administrators, and faculty to: set policy, identify services, oversee budget, evaluate program; assist in generating community resources.	General consent form that identifies all of the services available; Parent must be offered opportunity to identify specific services that they do not consent to being provided.	Must provide written agreement for provision of after hours and summer care; Must provide protocol for communicating with child's medical/health provider; Must describe mechanisms for exchange of medical, social and financial eligibility information.	Must participate in statewide data collection; Must provide protocol for physician involvement in record review and consultation. State health department conducts technical assistance and quality assurance site visits.
	Source: *School Health Programs Request for Proposals, 1994.*								